House of Representatives

General Assembly

File No. 131

February Session, 2000

Substitute House Bill No. 5292

House of Representatives, March 20, 2000

The Committee on Public Health reported through REP. EBERLE of the 15th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

An Act Establishing The Reporting Of Community Benefit Programs By Managed Care Organizations And Hospitals.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

(NEW) (a) On or before January 1, 2001, and annually thereafter, each managed care organization, as defined in section 38a-478 of the general statutes, and each hospital, as defined in section 19a-490 of the general statutes, shall submit to the Commissioner of Public Health, or the commissioner's designee, a report on whether the managed care organization or hospital has in place a community benefits program. If a managed care organization or hospital elects to develop a community benefits program, the report required by this subsection shall comply with the reporting requirements of subsection (c) of this section.

(b) A managed care organization or hospital may develop community benefit guidelines intended to promote preventive care and to improve the health status for working families and populations

at risk, whether or not those individuals are enrollees of the managed care plan or patients of the hospital. The guidelines shall focus on the following principles:

(1) Adoption and publication of a community benefits policy statement setting forth the organization's or hospital's commitment to a formal community benefits program;

(2) The responsibility for overseeing the development and implementation of the community benefits program, the resources to be allocated and the administrative mechanisms for the regular evaluation of the program;

(3) Seeking assistance and meaningful participation from the communities within the organization's or hospital's geographic service areas in developing and implementing the program and in defining the targeted population and the specific health care needs it should address. In doing so, the governing body or management of the organization or hospital shall give priority to the needs outlined in the Department of Public Health's recommendations on public health issues; and

(4) Developing its program based upon an assessment of the health care needs and resources of the identified populations, particularly low and middle-income, medically underserved populations and barriers to accessing health care, including, but not limited to, cultural, linguistic and physical barriers to accessible health care, lack of information on available sources of health care coverage and services, and the benefits of preventive health care. The program shall consider the health care needs of a broad spectrum of age groups and health conditions.

(c) Each managed care organization and each hospital that chooses to participate in developing a community benefits program shall include in the annual report required by subsection (a) of this section

the status of the program, if any, that the organization or hospital established. If the managed care organization or hospital has chosen to participate in a community benefits program, the report shall include the following components: (1) The community benefits policy statement of the managed care organization or hospital; (2) the mechanism by which community participation is solicited and incorporated in the community benefits program; (3) identification of community health needs that were considered in developing and implementing the community benefits program; (4) a narrative description of the community benefits, community services, and preventive health education provided or proposed, which may include measurements related to the number of people served and health status outcomes; (5) measures taken to evaluate the community benefits program results and proposed revisions to the program; (6) to the extent feasible, a community benefits budget and a good faith effort to measure expenditures and administrative costs associated with the community benefits program, including both cash and in-kind commitments; and (7) a summary of the extent to which the managed care organization or hospital has developed and met the guidelines listed in subsection (b) of this section. Each managed care organization and each hospital shall make a copy of the report available, upon request, to any member of the public.

(d) The Commissioner of Public Health, or the commissioner's designee, shall develop a summary of the community benefits program reports submitted under this section, review the reports for adherence to the guidelines stated in this section and report, on or before October 1, 2001, and annually thereafter, to the joint standing committee of the General Assembly having cognizance of matters relating to public health, in accordance with the provisions of section 11-4a of the general statutes, with an analysis of each report submitted by managed care organizations and hospitals pursuant to this section.

PH ***Committee Vote:*** Yea 25 Nay 0 JFS

The following fiscal impact statement and bill analysis are prepared for the benefit of members of the General Assembly, solely for the purpose of information, summarization, and explanation, and do not represent the intent of the General Assembly or either House thereof for any purpose:

OFA Fiscal Note

State Impact: Cost

Affected Agencies: Department of Public Health, University of Connecticut Health Center

Municipal Impact: None

Explanation

State Impact:

The Department of Public Health will incur an FY 01 cost of approximately $30,000 to retain consultant services necessary to summarize information on community benefit programs submitted by seventy-three entities (thirty-two hospitals and forty-one managed care organizations), analyze their adherence with guidelines set forth by the bill and issue a report by October 1, 2001. Ongoing costs will be approximately $20,000 annually thereafter.

It is anticipated that the University of Connecticut Health Center will incur minimal costs, which can be accommodated within its anticipated budgetary resources, to comply with the reporting requirement.

OLR Bill Analysis
sHB 5292

AN ACT ESTABLISHING THE REPORTING OF COMMUNITY BENEFIT PROGRAMS BY MANAGED CARE ORGANIZATIONS AND HOSPITALS.

SUMMARY:
This bill requires each hospital and managed care organization (MCO) to submit an annual report to the Department of Public Health (DPH) commissioner on whether it has a "community benefits" program. If it does, the report must describe the status of the program, and the extent to which the program has met certain guidelines. The first report is due January 1, 2001. While the bill does not define "community benefits," the term generally refers to efforts by MCOs and hospitals to improve and maintain the health of members of the communities they serve.

The bill also requires the commissioner to summarize the required reports and annually report to the Public Health Committee beginning October 1, 2001.

EFFECTIVE DATE: October 1, 2000

COMMUNITY BENEFITS ANNUAL REPORT

By January 1, 2001, and annually afterwards, each MCO and hospital must provide the DPH commissioner with a report on whether it has a community benefits program in place. It requires each MCO and hospital that chooses to develop a community benefits program to report annually on the program's status. The report must include (1) the MCO's or hospital's community benefits policy statement; (2) the mechanism for soliciting and incorporating community participation; (3) the community health needs considered in developing and implementing the program; (4) a narrative description of the community benefits, services, and preventive health education provided or proposed; (5) measures to evaluate the program results

and proposed revisions; (6) to the extent feasible, a program budget and a good faith effort to measure program expenditures and administrative costs, including cash and in-kind support; and (7) a summary of the extent to which the MCO or hospital has developed and met certain community benefit guidelines the bill establishes.

The hospital or MCO must make a copy of the report available to the public upon request.

COMMUNITY BENEFIT GUIDELINES AND PRINCIPLES

Under the bill, an MCO or hospital can develop community benefit guidelines designed to promote preventive care and improve the health of working families and populations at risk, whether or not they are members of the MCO or hospital patients. The guidelines must focus on (1) adopting and publishing a community benefits policy statement; (2) responsibility for overseeing the development and implementation of the program, resources to be allocated, and regular program evaluation; (3) assistance and meaningful participation from the communities in MCO's or hospital's service area in defining the targeted population and specific health needs to be addressed (the MCO or hospital must give priority to the needs outlined in DPH's recommendations on public health issues); and (4) developing the program based on an assessment of the health care needs and resources of the identified populations, particularly low- and middle-income medically underserved populations, and barriers to access to health care such as cultural, linguistic, and physical barriers.

SUMMARY OF REPORTS

The bill requires the DPH commissioner to summarize the submitted community benefits program reports and review them for adherence to the guidelines and principles. The commissioner must report to the Public Health Committee by October 1, 2001 and annually afterwards with an analysis of each report submitted by MCOs and hospitals.

COMMITTEE ACTION

Public Health Committee

Joint Favorable Substitute
Yea 25 Nay 0